HOUSE OF LORDS

SESSION 1989–90
4th REPORT

SELECT COMMITTEE ON
SCIENCE AND TECHNOLOGY

PRIORITIES IN MEDICAL RESEARCH

SUPPLEMENTARY REPORT

Ordered to be printed 25 April 1990

LONDON: HMSO
£4.65 net

HL Paper (51)

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FOURTH REPORT

25 April 1990

By the Select Committee appointed to consider Science and Technology.

Ordered to Report:

PRIORITIES IN MEDICAL RESEARCH

1. The Committee have followed up their enquiry into priorities in medical research (3rd Report, session 1987-88) by taking further oral evidence from the Secretary of State for Health, Kenneth Clarke, and the Parliamentary Under-Secretary of State for Education and Science, Robert Jackson. The evidence is published in this report, so that it is widely available.

2. The Committee also publish an exchange of letters with Mr Clarke, arising from the Government's White Paper on Priorities in Medical Research (Cm. 902).

MINUTES OF EVIDENCE

TAKEN BEFORE THE SELECT COMMITTEE ON SCIENCE AND TECHNOLOGY

WEDNESDAY 25 APRIL 1990

Present:

Adrian, L.
Butterworth, L.
Caldecote, V.
Clitheroe, L.
Dainton, L.
Erroll of Hale, L.
Flowers, L. (Chairman)
Hunter of Newington, L.
Kearton, L.
McFarlane of Llandaff, B.
Nelson of Stafford, L.
Nicol, B.
Rea, L.
Sherfield, L.
Taylor of Blackburn, L.
Walton of Detchant, L.
Warnock, B.

Letter from Lord Flowers, FRS
Chairman of the Select Committee on Science and Technology
to the Secretary of State for Health

PRIORITIES IN MEDICAL RESEARCH

1. The Committee are grateful to the Government for your Response on Priorities in Medical Research which was published as Cm 902. We have discussed the White Paper, after informal soundings across a fairly wide range of medical opinion, and the Committee have agreed that I should write this letter to you. I am copying it also to John McGregor, Malcolm Rifkind, Peter Walker and Peter Brooke.

2. Our initial reaction has been to welcome your proposals. As a result of the change in management structure for the NHS, which took place since we reported in March 1988, an alternative to our proposal for a National Health Research Authority (NHRA) is acceptable. We foresaw this possibility in paragraph 9.19 of our report, and I am glad that the Government and the Committee agree on the fundamental issue: the NHS should do more to identify and meet its own research needs and it should be brought into the mainstream of medical research.

3. A Chief of R&D, committed to the NHS and fully resourced, should be able to achieve our common objectives.

4. But I have to record serious reservations which have been expressed, especially among senior members of the medical profession with experience in this field. The Government have evidently got a big hurdle to surmount in convincing those concerned that the Chief of R&D will have the resources and independence to be effective.

5. For a start, the Response is silent on the all-important question of funds for R&D. What change will there be to increase the amount spent by the NHS on R&D from 0.001 per cent[1] of its budget?

6. In place of a National Health Research Authority, you have proposed a single individual who, as far as the NHS is concerned, is part-time. He or she has 10 major functions set out in pargraph 2.3 of the Response. These include two different branches of applied research—clinical research including epidemiology, etc, and medical audit and operational research—which are different enough not to be easily covered by any individual, except in a strictly administrative role. The CRD is not even to be given a seat on the Management Executive. You can understand the scepticism of those who think that the CRD will be ineffective. Their scepticism could be overcome if the CRD has sufficient staff to act, in effect, as an NHRA, and if he/she is primarily based in Leeds. I return to this below.

7. We hold firmly to our opinion that "the DH and the NHS both require research programmes but these will be different in scale and kind. There is a clear distinction between the

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[1]For correction of this figure, see Q1.

needs of ministerial policy and of NHS research" (paragraph 9.16 of our Report). This opinion has been endorsed by many practitioners since 1988. Your Response is ambivalent on this. In paragraph 2.5 you say that "the new post will preserve the individual research interests of DH and the NHS while giving a good opportunity to build good and strong links between them". The new post will also act for and advise the NHS Management Executive, which is itself meant to have an existence separate from the DH. But everything else in the Response seems to suggest that NHS research is to be planned and commissioned from the DH.

8. We are particularly concerned by the statement in paragraph 2.8 that "the CRD will be supported by a research management division consisting of staff from both DH and the NHS", implying a single structure not two separate ones. This, coupled with the CRD's dual responsibilities, could suggest that little has changed from the present, other than the length of the CRD's working week.

9. It is also unclear whether the statement "NHS research should stay within the mainstream of NHS management" (paragraph 2.10) implies that the research should be controlled by management. Without a degree of visible independence from management, the research will decline in quality and usefulness.

10. It may be that we have misinterpreted the Response. If so, we would be very happy to be assured about your intentions.

Can I put some specific questions in this context:—

(1) What number of professional staff will support the CRD?
(2) How many of these will have direct experience of research and/or the administration of research?
(3) Will the CRD have one research management division concerned with both DH and NHS research, or two divisions for DH and NHS separately?
(4) After 1992, will the CRD work more from Leeds than from London?
(5) Will the CRD have a clear responsibility for line management of research within the NHS, with delegated authority from the NHSME?

11. A further area on which we seek reassurance is that of manpower. It has been suggested to us that your statements in 3.11 and 3.12 are really meaningless in addressing the problem of manpower shortages because, with the cut in size of academic clinical departments, few talented people are going to be able or tempted to have a long-term career in academic medicine. If so, your new edifice would be undermined. We are very disappointed in your response to the problems disclosed in our enquiry relating to manpower planning, training and education and the career prospects for research workers. The Response does not seem to recognise the urgency and importance of this issue.

12. We welcome the decision to increase SIFT, with the intention of meeting 100 per cent instead of 75 per cent of the excess costs of teaching hospitals in teaching and research activity. But SIFT in its present form is far too small to have any prospect of covering the costs of clinical research, and an increase of 2 per cent will hardly change this. We also want to press our suggestion that SIFT should become SIFTR, to act as a reminder that it is not related only to teaching activity.

13. Paragraph 2.25 of the White Paper states that "no consent to publish has been withheld since the research contract conditions were revised in 1987". We are informed that this is not true: there have also been examples where publication has been delayed, almost to the point of censorship.

14. Then there are some other points on which the Response is silent.

15. Will the CRD be included in the DH's decision-making discussions about bids for money in the annual Public Expenditure round?

16. The White Paper has not addressed the need for public health research and operational research. Few health authorities will spend money on this type of research, particularly if the results are likely to be of *both local and national* interest. What incentive is there for health authorities individually to support such research?

17. We await the outcome of Sir Christopher France's report on medical and dental education to see what prospect there is of real co-operation between the NHS and university teaching hospitals.

18. Finally, I suggest that this matter might be suitable, at a convenient time, for a public exchange of views, in a session of oral evidence or in debate in the Lords. Would you welcome such an opportunity?

FLOWERS
6 *March* 1990

Rt Hon Kenneth Clarke QC MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Letter from the Secretary of State for Health to Lord Flowers

PRIORITIES IN MEDICAL RESEARCH

Thank you for your letter of 6 March setting out the views of the Select Committee on Science and Technology on the White Paper on "Priorities in Medical Research". I am glad to see your general welcome to my proposals.

I think that it would be interesting and helpful to discuss with the Select Committee the plans we have in mind for the work of the Chief of Research and Development, and more generally for protecting medical and health research within the NHS.

I have asked my office to contact the Committee Clerk to arrange a convenient time. I look forward to meeting with you and your colleagues in the Science and Technology Committee.

Copies of this letter go to John MacGregor, Malcolm Rifkind, Peter Walker and Peter Brooke.

KENNETH CLARKE
3 *April* 1990

Examination of Witnesses

RT HON. KENNETH CLARKE, QC, a Member of the House of Commons, Secretary of State for Health, and MR R JACKSON, a Member of the House of Commons, Parliamentary Under-Secretary of State for Education and Science,examined; SIR CHRISTOPHER FRANCE, Permanent Secretary, Department of Health, and MR J VEREKER, Deputy Secretary, Department of Education and Science, called in and examined.

Chairman

1. Secretary of State, may I, on behalf of the Select Committee, welcome you very warmly indeed to this meeting and thank you for being prepared to discuss with us our letter to you, and, of course, we welcome your colleague from the Department of Health, Sir Christopher France, and Mr Robert Jackson and his colleague Mr Vereker from the DES. I am glad to see all four of you. May I say to start with that we recognise that our concerns are being taken seriously by Government in general and by you, Secretary of State, in particular. We are grateful for that and we hope that our discussion today may carry that a useful step further. Before I invite you to talk to us perhaps I should draw your attention to the fact that in paragraph 5 of my letter to you we made an error by a factor of 100 in the percentage of total spend that went on R&D. It should have said a fraction of 0.001, or 0.1 per cent., not 0.001 per cent. However, we did know we were talking about £25 million out of a total of £28 billion, so it was a typing error rather than an error in our understanding. That leads me to say, of course, that the sum is still pretty small, so we would be very interested in anything you might say about your intentions to increase the R&D budget and how seriously R&D is going to be taken in future within the Department of Health. But, of course, what we would like you to do first is to make any remarks that you wish by way of general introduction and response to our letter and in particular to explain some of the announcements that were made in the House yesterday by Baroness Hooper, which some of us unavoidably missed. I did, for example. Secretary of State, thank you for coming, and over to you.

[Chairman *Contd*]

(Mr Clarke) My Lords, thank you very much for giving me the opportunity to give this evidence. As you say, it is an extremely important subject upon which I think we are making progress, firstly, in response to the excellent report of your Sub-Committee and also in response to the letter that you kindly sent to me by way of preparation for this meeting, covering some of the areas that you would like to touch on. I certainly would like to begin by underlining our commitment to research, and high-quality research, in the National Health Service not only in our response to your report but in the evolution of our reforms, which this House was discussing yesterday. I think we have to ensure that the role of research is properly looked after and that we maintain a high quality and can fill in the gaps in our research policy where we find them existing. So far as the paragraph you touched upon is concerned, I was not going to raise the mathematical error because the underlying point I feel you are wishing to make is that plainly we must put an amount of resource behind our research department effort which is required by the Service. I think, with respect, it is difficult to define what is needed in terms of the overall expenditure of the Health Service particularly so far as my Department is concerned, to cover the whole range of medical research, operational research, research into the medical services field as well as the straightforward clinical field. I also feel the starting point is there. When you look at the amount of public funds and voluntary funds going into research in the health field, it is a much bigger figure than just that small proportion of the NHS budget. Obviously Robert Jackson is responsible for the Research Council budget but we also have the charitable budgets in the medical research field and we have many other budgets helping the budgets in our agenda and I think if one imagines that £25 million as somehow summing up the total research expenditure in the National Health Service that is a serious under-estimate. The candid truth is that probably we have no accurate measure of the total extent to which resource and time are being put into research out in the field. Maybe it is something that the new Director will want to look at, because in the majority of hospitals in this country there are all kinds of clinical research projects being engaged in by consultancies in one way or another who are going to affect this in the way of the figures you have. The important thing is the kind of sums of money we are going to aim at and I think my reaction to that would be that plainly we absolutely will want to hear what the advice of the Director of Research himself is going to be. The point of creating this new role, giving someone that new authority in the Service, is that he will himself survey the field and give us advice about the adequacy of the resource being devoted to things he believes that the Health Service and the Management Executive should be doing. He will be involved in the public spending process and in helping to formulate my public expenditure bids as far as the Health Service is concerned, and I think it has to be carefully balanced to try to put a percentage figure on the total which somehow we should aim at. I imagine predictably the first thing the new Director will do in surveying his field is to start addressing himself to the propositions he wants to put forward about the kind of resource he thinks is going into this area of the Health Service.

I followed yesterday's debate and Baroness Hooper did actually make some announcements which were a reaction to your letter. Your letter was extremely helpful. You welcomed the response we had given to Lord Nelson's Sub-Committee's report, which has raised all kinds of activities in the areas where you were disappointed, and one of the things we obviously had to address ourselves to in the context of the Bill before the House was the role of the person we were calling the Chief of Research and Development and how he fitted into the system. For that reason Lady Hooper had the opportunity yesterday of telling you we had revised our opinion in the light of your letter and decided to go for a Director of Research and Development, making him a full member of the Management Executive, which Lord Nelson, both publicly and privately, had urged on me in the past, and putting him in the middle of NHS management. I think I should make it clear that as far as the Health Service is concerned he will now be in a role which I think enhances his clout and credibility and puts him at the centre of decision-making, though obviously he has some activities that extend outside the Management Executive so far as the Department of Health's overall role of policy and strategy is concerned. He will also have Social Services duties as well because we are responsible for personal Social Services and I want him to have an input into that as well. But that was the response yesterday, which I hope your Lordships found helpful.

Chairman] Thank you very much indeed. I am sure you will find that out during the course of this morning! You mentioned Lord Nelson, so may I call upon him, following his splendid report which deals with many of the things we shall be talking about. May I ask him to come in and discuss with you the question of the Director and what his responsibilities are likely to be.

Lord Nelson of Stafford

2. Thank you, my Lord Chairman. I would like to endorse what our Chairman has said, that we very much welcomed the response from the Government to our report. We think it was encouraging in the first place. On the appointment of a Chief of Research and Development we had some reservations, which had been passed on to you, and we very much welcome the development which has subsequently taken place.

I think the move to a Director of Research is very much in line with our own thinking, and for him to be a part of the management of the National Health Service as a member of the Management Board was in our opinion fundamental to the credibility of the

[Lord Nelson of Stafford *Contd*]

appointment within the Service and within the medical profession. That stemmed, as I think the Secretary of State knows, from the reaction which we had received from many quarters within the Service indicating that there was doubt about the effectiveness of the original proposal, and this I am sure will go a long way to rectify that position. So that is indeed to be welcomed. Also I note that Baroness Hooper in her statement said there is still on-going thinking in this and that is again very welcome. It is an on-going exercise to make this as effective as possible. Within that we would hope that the Director of Research will, in fact, have his headquarters at Leeds as part of the management team. Many of us think it is very important that he should be within that team so that he is meeting the other executive directors every day, albeit that he has the important role to play in advising yourself in relation to the Department's own research needs. So all this I think augurs well. I would like to make just one or two comments on the other parts of your response on which you might choose to say something, and this could be helpful to subsequent questioners. We were not altogether happy with your response relative to the question of operational research and development. It is referred to but we did think it was a really grave weakness that an organisation the size of the National Health Service had not got a more competent, permanent team of researchers on the operational side which could, in our opinion and in the opinion of those who gave us evidence, more than pay for itself out of the contribution it would make in improving the effectiveness of the service. So the question of operational research is an important factor within our recommendations and we would welcome any comment you make on that. The other thing that we referred to was the career prospects for research staff. This is extremely important. There is a feeling which came through to us very strongly that career prospects for research in the medical field are not attractive and we had in mind—I am not quite sure whether it is still your thinking—that the Director of Research could make it one of his responsibilities to ensure that the career prospects for research workers are attractive and thus attract people of the right quality into the bottom end of the service. You will only get the good people at the bottom end if there are good opportunities at the top end. It seemed to us there was nobody really responsible for ensuring this, and this is an important factor for the future of the National Health Service. One further element which I think will be covered by your thinking on the policy of the Director of Research is the protection of clinical research within the National Health Service. It was very clear to us from the evidence we received that clinical research was coming under very considerable pressure, to put it that way, as a result of the financial constraints on the National Health Service and of the pressures of patient care. We did think that there should be somebody responsible within the National Health Service, as is the case we found in the United States, to ensure that clinical research is adequately protected against these pressures which are indeed very great and understandable. There is no point in spending large sums of money on research if in fact the steps to bring them to fruition, namely clinical research, are themselves artificially restricted. So those are the brief comments I would like to make. Many other members of my Sub-Committee and the Committee have their own questions but that is my first reaction to your response.

(Mr Clarke) Firstly, my Lord, I entirely accept that one of the main concerns of the Committee was the credibility of the new post, as Lord Nelson just said, and I do not think there is anything between us. There is a desire to establish somebody who has clout and authority within the organisation and who will influence the approach of the National Health Service and guide the Executive to giving the proper priority to research. Hence the appointment of a Director on the Executive. To touch on one particular thing Lord Nelson mentioned (I cannot remember if Baroness Hooper covered it yesterday), the question of whether the Director would be in Leeds, he certainly should be in Leeds. I attach considerable importance to Leeds. I happen to be in favour in any event of getting more Civil Service and Government employees out of London and around the country for a variety of purposes, not just cost. But also I personally attach some importance to the Management Executive of the Health Service having their own corporate identity in Leeds and that part of my Department being up there. One of my main aims is to depoliticise to a certain extent the management and operation of the Health Service, to give some more autonomy and clout to the people who are actually responsible for the management and delivery of the service. I happen to think there is a certain symbolism in putting that part of the Service into Leeds where there can be day-to-day contact. There has to be an awful lot of liaison between Leeds and Whitehall; nevertheless, I think all the directors, including the Director of Research, should have their own distinct identity and their own head-quarters up in Leeds. We will certainly do that.[1]

Chairman

3. Forgive my interrupting you. Do you see the Director as your man who spends part of his time helping the National Health Service or do you see him more as a NHS man spending part of his time helping you?

(Mr Clarke) I see him as a NHS man, as I see the rest of the Executive. I think we are setting up this Executive in order to have a clear management identity. They are part of my Department; nevertheless they are the people who are charged with the management responsibility and what flows

[1] *Note by the witness:* The Director of Research and Development is expected to spend most of his time in Leeds and the rest in London.

[Chairman *Contd*]

from that so far as the Service is concerned. He will therefore be part of the Executive. Like the other directors, he will have direct access to me. So far as the National Health Service is concerned, he will act as a member of the Directorate. He will also have certain work which lies outside the Executive, because we do want someone to act as adviser to the Government as a whole. The arrangements we are proposing are that this Management Executive will deliver the service in response to national priorities determined by the Government for which the Government is accountable to Parliament, and we will need his support necessarily in research and development in evolving our priorities.

So we have some work on this but he was going to lead the protection on clinical research. There are two things there. Firstly, obviously one of the prime duties will be to make sure the Executive does protect the position of clinical research in deciding its priorities and the day-to-day management of the Service. Secondly, we have to make sure that the process of reform is conducted in such a way that clinical research is protected and is available in any health care system at any time. There are going to be these competing pressures. There are always going to be pressures coming from the demands for more services and somebody has to make sure the research role is not unduly inhibited by that. That is particularly being addressed by the France Group, Sir Christopher's group, which is now having a look at SIFT and "knock-for-knock" and all the other arrangements. I personally think obviously that was due for a review in any event. As it happens it is a good time to be doing it alongside the reforms because the nature of SIFT and the makeup of SIFT and what it covers and so on are important and we have to ensure that the contracting arrangements inside the Health Service do not squeeze out research by disadvantaging those people who are engaged in research, which is exactly what the France Group is doing. As to career prospects, it is probably best for Robert to come in and handle career prospects for those engaged in research, which Lord Nelson touched on.

(Mr Jackson) Would you like me to do that now?

Chairman] I thought it might be helpful if Lord Adrian took up Mr Clarke on one point.

Lord Adrian

4. It is a small point. It is just to quote what Baroness Hooper last night or yesterday afternoon said of the duties of the new Director: "The duties other than those relating to the National Health Service which we envisage will, in fact, form the major part of the new Director's duties relate to policy directed development which feeds into the National Health Service." That seems to me to be a slightly different emphasis and I wondered how far the Director's duties are clearly set out at this stage and how far they are for discussion and development?

(Mr Clarke) I was surprised she thought they were the majority. The answer has to be we have clearly set out his duties. We certainly have not strictly allocated the time within that but the area of duties is clear. The duties so far as the NHS is concerned are that he will act as a member of the Executive and then he has his duties, working to the Secretary of State, of helping the Government on public health policy generally and drawing up national policies and strategy for the Service. For that he will work to the Secretary of State in the other part of my Department and then—I will not mention it again but personal social services was another area. When you look at these various categories I also think we should all guard against dividing them up too artificially. I think someone made reference to operational research vis-a-vis clinical research. It is extremely important that he manages operational research and there is broad scope for that in the Service, and the more we try to reform and change, the more we need to ensure that we are carrying out the proper level of operational research. There are a lot of things we are going to look at. To give you an example which comes to mind and which I hope stands up: the steady development of day surgery, innovative treatment inside the Service, needs to be backed up by proper research and evaluation. What we are looking at is the clinical quality and the impact on patient care of a move to a higher proportion of day surgery in the Service, helping the cost-effectiveness of the resource and how it is organised. I am not quite sure how that subject will wholly fall within the NHS Management Executive role, but whether you call it clinical research or operational research we would not want to divide it but take an overall look.

5. But given the diversity of the duties of the new Director in the operational research field, do you know how far the Director has gone in terms of dividing up his time?

(Mr Clarke) I do not know if Duncan Nicol knows how he divides up his work, working so many hours in one and so many in the other!

Chairman

6. I think, if I may say so, it would help us, Secretary of State, if you could give any idea at all, however sketchy, of how you see the Director's staff. I do not mean at the lowest level. What would his immediate responsibilities be as expressed by the staffing structure? I realise it is early days.

(Sir Christopher France) At the moment the Research Management Division in the Department is about 45 strong, all told. We are considering about a third increase in that. But that need not be interpreted, as it were, as allocating its time one quarter to the National Health Service and 75 percent to other work, because some of the work already done in the Department is directed towards that core operational research which is a particular interest of the Committee. So certainly there is an

[Chairman *Contd*]

intention to increase the size of the staff, and certainly there is an intention to draw that increase from the National Health Service. There will be, as it were, a two-culture approach rather than a single culture approach.

Lord Kearton

7. As a member of Lord Nelson's Sub-Committee, I welcome the constructive attitude of the Secretary of State but I would like to underline what Lord Nelson has said about the career structure in medical research. It is really at the moment the biggest dilemma facing the medical charities. At the moment medical charities (and I am associated with one of the major bodies) are now spending the best part of £150 million a year in medical research—about the same as the Medical Research Council —and what we foresee is that, unless something is done about the whole salary structure, which implies a National Health scale input, the post doctoral fellows who do most of the medical research anyway are going to dry up rather dramatically. So, whatever plans we make for more medical research, unless they get a better paid definite career structure for young medical research workers, they are doomed to failure. I hope Mr Jackson and the Secretary of State take this point. All the moves you have made are very constructive and I would like to see one further step to make the Director of Research and Development a grade 1 post, which would underline the fact that he has status and clout even if his level of salary is still modest. Therefore, to a certain extent to get the best results you need to have something like a prestige grade 1 post rather than a grade 2 post to get applicants of the necessary prestige.

(Mr Jackson) Could I say something about career structure? We recognise that this is a problem. I think the root of the problem has been the vast expansion in the number of contract workers in higher education in recent years. We have an overall figure of 14,000 research workers in universities who are not wholly university-financed, and that is more than double the number in the mid-1970s. Clearly it is not feasible to envisage that they will all find employment in higher education when they have completed their short-term contracts. That is simply inconceivable. In a way, this is a problem of success, is it not? It is the consequence of the diversification of the income of universities, the growth of charity input, the growth of funding from industry and so forth, which has enabled a lot more short-term contract researchers to be employed. The problem is their career prospects beyond that. This is a serious problem. It is one that the CVCP are addressing and there is some discussion of the possibility of a code of practice. I think that would be a helpful development. I do think one of the points though is the need for there to be more willingness to move on into other employment, particularly industrial employment. I have some quite interesting figures here on the first destination of students who have completed MRC studentships in 1988. It is interesting to see that 31 per cent (61 students) went on into United Kingdom fixed term academic appointments. That is not bad. Only 0.5 per cent were able to get a permanent appointment at that stage—perhaps not surprisingly—but only 9.5 per cent (that is 19 of them) went into United Kingdom private sector industry or commerce, and I think it is quite important that we should develop routes that lead from doctoral study and post-doctoral research contracts on into industrial employment and other employment rather than thinking of the higher education sector as being the necessary employer of all this burgeoning number of contract researchers.

8. It does depend on the quality of the people and, speaking again from what experience I have of medical research charities, over the last two or three years the quality of applicants is certainly not what it was. The reason is because the prospects are so poor, and so you get a recurring cycle which is bound to go downwards. In other words, people who are going into this now do not have the high qualifications which a lot of people in industry want to see, with some added clinical research on top of that, which is valuable. You must have the right starting material and the starting salaries are abysmal.

(Mr Jackson) Are we talking about people coming in at the studentship level or at post-studentship level?

9. We are talking about post-doctorate students and also about setting up research departments where you want people at lecturer level and so forth.

(Mr Jackson) Monitoring of this point about the quality of applications is probably rather difficult, because of the diversity of funding sources at that stage. But perhaps it follows, if there is a growth in opportunities, that it may well be that more people are being sucked in and that the quality may be going down. But we have looked at quality levels at the level of appointment to studentships. The number of studentships has increased quite substantially overall and within the MRC has increased quite substantially after a dip in the mid-1980s. What emerges from this is that, if you look at the quality of the final undergraduate degree, there does not seem to be any evidence of deterioration in quality. The proportion of people with firsts and 2.1s is being maintained.

10. From experience I have noticed the number of firsts has gone right down. Out of 27 applicants for a post only one had a first. That is an absolutely new experience for us.

Chairman

11. Mr Clarke, would you like to comment on Lord Kearton's other question? If you are trying to get somebody who will command respect not only in the Department but in the world outside, at grade 2 that person is likely to have to take a cut in salary.

[Chairman *Contd*]

(Mr Clarke) We have to have an eye on the senior management structure of my Department. My current score, I believe, for grade 1 posts is the Permanent Secretary, the Chief Medical Officer and the Chief Executive of the National Health Service. I do not think we have any more, we have three. Grade 2 is pretty senior; but not only are there constraints, there ought to be constraints on a comparatively new department. We have already put the score up by 50 per cent in breaking away from the DHSS and increasing the grade 1 posts. Having said that, I quite accept the force of the point about salary for the kind of character we are looking at. Depending on whom we appoint, the possible use of secondment could get over that problem. That is one way we might have to tackle it. We are open to using that if we have to. But I cannot be too encouraging on the prospect of doubling the number of grade 1 posts we have in the Department in two years flat.

Viscount Caldecote

12. I think the line of management authority is extremely difficult to understand from the job description. The Director of Research and Development reports to the Permanent Secretary and will also report to the Chief Executive of the Management Executive. I am not quite clear to whom the Chief Executive of the Management Executive reports, to you or to the Permanent Secretary?

(Mr Clarke) To me.

13. So he has two masters, this poor man.

(Mr Clarke) We are gradually evolving this development since we introduced the Management Executive. We get the Management Executive inside the Department, drawing the distinction between the management of the Health Service on the one hand and the overall national strategic policy objectives for the Service on the other. Again we do not make too artificial a distinction because there is a grey area between these two obviously. In the health care system there are quite a lot of people who work within the Department who report to the Management Executive but who are themselves civil servants and who for certain purposes report to the Permanent Secretary. As we have bedded down, though it does not make very good charts, it is not proving too difficult in practice. Dealing with the present members of the Management Executive who are headed by the Chief Executive, Duncan Nicol, who reports to me, the position so far as the members of the Executive are concerned is that a clear majority come from the Service and are not civil servants; nevertheless, there are some civil servants, including grade 2s like Michael Malone-Lee, a grade 2 Deputy Secretary in my Department. He is a member of the Executive who reports to Duncan Nicol for Executive responsibilities and also reports to Sir Christopher for those parts of his responsibilities which relate to the overall public health duties and so on of the Department. In practice, this does not give rise to great difficulty.

For all his National Health Service work the Director would be a member of the Executive, reporting to the Chief Executive, with the right of direct access to myself, but he will also have certain responsibilities within the other part of the Department, again reporting to Sir Christopher; I will not repeat it again but, for example, the personal social services work, where it is quite plainly not, at the moment anyway, within the remit of the Health Service.

14. Are those latter responsibilities mainly advisory? Surely his Executive responsibilities for research do not refer to many of those things you were talking about? They are advisory?

(Mr Clarke) Let us say he carries out research, either of an operational or other kind, into care in the community policies. Actually I think we fall in that area in the first place straight into this difficulty of drawing divisions. We would not want to draw rigid divisions. One of the extremely interesting things we have to get right is the relationship between the NHS and clinical services and the personal social services of the local authorities in developing better care in the community policies. In so far as the NHS is involved, and that stands for the Executive, these are absolutely the DRD's responsibility, to make sure the NHS is properly organised to co-operate with local authorities and deliver its share of the necessary support for that area as far as the social services are concerned. He might very well carry out research in that area, but I think there is a lot of need for operational research and developing better methods of getting co-operation at grass roots level between the different authorities, the different professions, and developing cost-effective methods of delivering care.

Chairman] But, if I may say so, our puzzlement arises mainly from the fact that you are declaring a deep interest and concern about research in the Department of Health for the first time and that changes the way one has to think about the relationships.

Lord Dainton

15. I very strongly agree with what the Secretary of State has said about the problem and not being too prescriptive at the beginning. To a certain extent the range is so great and the resources so unsure and the boundaries so blurred that a lot of the work of writing his own programme of work will have to fall to the Director when he is appointed, but it will carry his own mark and he will have to think up his own relationships. But that vastness of range of interests is the thing which fascinates me and at the same time worries me. When we had the debate yesterday I got a very clear sense that all parties, whilst they very much welcome the notion of the Director, also felt it was extremely important that this research should be

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of the highest quality and that, moreover, its impact, if any, on the operation should be assessed very carefully and lessons should be drawn from it. In a sense part of the research is investigating the impact of the research and the changes induced by it there and, indeed, in other fields. The thinking is, I think, that a lot of people felt it was very desirable not only to have this evaluative role but it also had to be absolutely clear to the public at large and everybody else that the Director was the recipient of a lot of independent advice from people who really knew. By that I mean the staff of 45 or 60 or whatever it is, who of course by themselves cannot possibly cover the range at the level of quality you want in assessing the research which has to be done, the programme you lay out and, indeed, the quality of the work when it is done. So there is a good deal of support, I thought, for the notion of an advisory council, which Baroness Hooper was quite clear in rejecting. I think it would be very interesting for us to know what your feelings are towards any evaluative role which the Director and his staff might have, acting as it were as a kind of internal monitor, policeman, whatever you like, on almost any aspect of the work of the National Health Service and, of course, the same role in the Department of Health, and also whether you do not feel that there might be a case for the Director, who, if he were to come in, might himself suggest it was desirable for the sake of developing authority in the sense of independence, to have an advisory council, and, if he were to do this, whether this would fall on deaf ears or be discussed? There are a lot of things there, I am afraid.

(Mr Clarke) The range, I quite accept, is very wide and I think it is important that what matters particularly is its impact on the evolution of policy in all these areas. The main impact will be the extent to which he gets the Executive to accept his views on the research programme that is required and then to ensure that his colleagues take note of the extent of his evaluation and researching as we develop. The advisory committee, I must admit, I am not attracted to in the form of the amendment yesterday, certainly for this reason. I begin by accepting the argument, of course, as Lord Dainton says, that one man is not going to cover all this. He is going to need a range of other people, all putting forward suggestions. Personally I have always envisaged that way of proceeding rather in the way the Chief Medical Officer does in the variety of things I find myself asking him to deal with. He tends to put it together for you. He has some standing advisory committees but his preferred method is to put together an ad hoc group of people. I am sure that if he were asked he would say he was in no position to give the Secretary of State of the day advice on any medical subject which comes up all the time. What he is there to do is to be able to judge who are the people outside he can go to and come together and say, "These are the people who are, in my opinion, best placed to give advice on that subject," and we are forever setting up groups of people of one kind or another to deal with problems as they arise.

I see the Director as doing that rather than an advisory committee of the statutory kind proposed yesterday or telling the Director he would have to face a committee. I think in so far as they require them members may nominate—it might be some of the professional bodies, some various academic interests. There is no other Director of the Executive who actually is charged with the business of being advised by a set group appointed by other people outside. My own reaction is that I am not sure it does add to his clout and credibility though it may be an additional resource.

16. I just wanted to clarify the kind of matter that we had in mind to those who proposed the amendment.

(Mr Clarke) That is my first reaction on that.

Chairman

17. If I may interpose one remark, we are dealing not only with the peculiarities of Ministers and Departments but also with lots of medical and research professions and you wish to bring them into your affairs and they are much more likely to feel they are brought in if they know there is a council with the sort of people on it who have been described. I am not talking about the statutory nature. They are much more likely to feel they want to come in.

(Mr Clarke) What we are envisaging, I am sure we all agree, is a Director who will want to establish his credibility, just as this Committee wants to establish his credibility. The Director will not do that unless he fairly rapidly involves the clinical and academic community in his work, so there is probably not anything between us. My reaction to the amendment was that here is a statutory body with all of them being given a right to appoint certain people and the Director charged with taking their advice across his whole field. If the Director went out and started to form sound advisory committees, that might be a very sensible way for him to proceed. I entirely accept that. I think if he were sensible he would try to do that, to establish some credibility in the field. I do not see anything between us on this.

Lord Dainton

18. Could I make a comment on the proposal and the amendment yesterday. It was not in any of our minds to have any representative sense in the crude way that has always been suggested but what one did feel is that the appointment of the top bodies —I know in my own experience—for particular topics does not solve the problem that in the medical field in particular there are a whole range of different areas which impinge on one another. If you consult them separately you get one answer. Unless you get

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them together and get them addressing the problems which you see in the Department as a whole you will not get the benefit of the advisory committee, council, whatever you call it, the thing we were pressing for, nor will you satisfy people outside unless you get people of the highest quality in such a body and you make it reasonably public. Could I add one further point, which is a question. You did say, Secretary of State, that you thought that it might be desirable in all the circumstances to appoint the new Director on secondment. I would hope that that might not take place. My experience of secondment jobs is that the person who is seconded inevitably is known to be temporary and loses in clout and influence. This is an extremely important post which is being introduced and I do hope it can be something which is sufficiently attractive in permanent possibilities to get very good people.

(Sir Christopher France) Could I perhaps respond to that and add one or two other points? On the secondment point, a large number (including the Chief Executive himself) of the members of the Management Executive are on secondment and I think it would be wrong to assume that that is seen as in any way reducing the status or responsibilities that they carry. It is rather an attempt to square two circles. The first is the desire to bring two cultures together so that it is not a question of the Department in a Whitehall ivory tower dropping bombs on the National Health Service, if I can put it that way. The second is to get round the problem that was mentioned earlier on that can arise over salaries and status. It is sometimes the case that people who would dearly like to do the job do not want to lose entirely their attachment to their previous organisation. It is even more often the case that the kind of remuneration on offer on Civil Service scales is just not sufficiently attractive. So then secondment is seen as a way of helping with these two problems and is certainly not seen as something which reduces the status of the individual who comes into the Department on those terms.

Lord Kearton

19. That is very attractive, Secretary of State. When you mentioned secondment that struck me as the way of getting over the salary question and starting off with someone with considerable status in industry at large.

(Mr Clarke) It is working very well. I think when we first set up the new Management Executive there was a suspicion in the Service that these were all going to be civil servants and were going to be the Department wearing different hats, not people from the National Health Service. Actually to take three of the leading figures in the Executive we now have, the Chief Executive is seconded from the National Health Services and is very much a National Health Service man, a regional man; but we have already mentioned Michael Malone-Lee, a Deputy Secretary from my Department, a civil servant; and the Director of Finance is seconded from the private sector, a lady called Sheila Masters. It is working in a way which I always wished. You do not actually see a clear divide. When you see the Executive and meet them collectively it is not the case that there is a faction from the Civil Service, one from the National Health Service and one from the private sector. It is gelling together extremely well and it is a bonus point on top of that, in my opinion, that we get over all these salary/senior management structure problems that would constrain the attractiveness of the posts.

Lord Dainton] I am grateful for that because my past experience of chief science advisers in the DHSS was on my own knowledge rarely satisfactory. I think it may be now due to other causes—namely, the fact that they were not members of any management executive or its equivalent.

Lord Hunter of Newington

20. Secretary of State, I have two questions. First, is the Chief Medical Officer on the management board? Second, how do you see the future relationships because the Chief Medical Officer has a very wide responsibility, particularly in relation to public health and, as you said yourself a few moments ago, has been enormously helpful in getting ad hoc or temporary advice of a particular variety when it was needed and, of course, you may be seeking a Chief Medical Officer within a few years' time. So it is frightfully important, is it not, to decide the relationship between the two, the Director of Research and the Chief Medical Officer?

(Mr Clarke) At the moment on the Management Executive there is a Medical Director. She is also actually Deputy Chief Medical Officer. She is a doctor and a professional civil servant and she combines the posts of Medical Director for the Executive, for which she is accountable to the Chief Executive, and also Deputy Chief Medical Officer for which she is accountable to Sir Donald Acheson. The Chief Medical Officer is a grade 1 appointment. He is not only my medical adviser but we regard him as the Government's medical adviser on public health matters generally. It would not be right for him as the Government's Chief Medical Officer to be a member of the Management Executive accountable to the Chief Executive, so we have this arrangement, which sounds like a hybrid, which at the moment is working quite well. Again I think I ought to give the Permanent Secretary a chance to comment on the structures we are evolving at the top of the office.

(Sir Christopher France) The structures are complicated, but we are dealing with a complicated organisation, the essence of which is that there is a single line of political accountability for a large operational organisation, the National Health Service, and a very much smaller government department which underpins the Secretary of State. But there is only one Secretary of State and it is necessary for the two lines of his responsibilities to

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have a constructive relationship together or else it would spell trouble for him. That is why we are trying to develop this arrangement whereby the Management Executive has a clear line of accountability to the Secretary of State—not through me—for the management of the Health Service. I do not get involved in the management of the Health Service but where issues which run wider than the management of the Health Service come up, then I of course get involved and so do those who report to me. It would, I think, be suicidal to try and be prescriptive about precisely where the borderline comes and stick to it, come what may. If, for example, an issue of food poisoning arises outside the Health Service, then the Health Service is merely a recipient of some general advice for avoiding it; if it unfortunately arises in the Health Service, then the balance is a different one and we have to have an organisation which is capable of dealing with these shifts of balance. As the Secretary of State has said, the Chief Medical Officer has wide responsibilities over the whole of public health. They are unaffected by our endeavours through the creation of the post we are discussing to sharpen up the Department's and National Health Service's concerns for research which has, as it were, a longer term focus. The Chief Medical Officer I am sure will want to pose questions that should be researched.

21. There is no question of changing the Chief Medical Officer's responsibilities in regard to other government departments?

(Sir Christopher France) None whatsoever.

Lord Walton of Detchant] Could I come back to one point which arose out of the earliest comments by the Secretary of State? I was very glad indeed to hear of his total commitment to the principle of research in the NHS. Now, if one looks at the support of research from the Department of Education and Science through the MRC, that is based on a dual support system with universities providing the infrastructure and environment and direct costs being covered by the MRC and by the charities. I take it from what the Secretary of State said he is in favour of a similar type of dual support arrangement within the NHS whereby the hospitals provide the environment and facilities etc. Funding was mentioned in last night's debate, but very late, and concern was expressed by Baroness Robson who pointed out that many of the charities supporting medical research are now being compelled by virtue of the shortage of certain clinical facilities in the NHS to devote some of the funds they have been given for research to the provision of clinical services without which the research could not be performed. I think this is an issue which may relate to the very point you raised at the beginning, that identifying costs of research within the NHS ought perhaps to be a task of the new Director of Research and Development.

Lord Kearton

22. Could I reinforce what Lord Walton has just said. With regard to medical research charities in this country, and particularly the foundation with which I am concerned, they support 21 professorships and various research groups—we have a meeting of all 21 professors this evening. What I find going round is that the clinical load of most professors is beginning to outweigh their research. In other words, they are beginning to subsidise the National Health clinical funds in a massive way. When I read paragraph 6 of the submission of the Secretary of State it sounded slightly grudging to me. What the research charities were told is that they may have to increase the cost of those patients because of an increased number of tests and so forth. That is where they have got the cart before the horse. At the moment medical research charities—every one I have looked at—are supporting or subsidising the National Health Service.

(Mr Clarke) On that last quotation, it is not meant to be disparaging. It is an acceptance of the fact that research work in the health field can add to the service costs for desirable reasons.

That leads to our search for ways of breaking down that additional cost and we are making additional distributions of funds of money for the patients and so on. On the main point, I know charities expressed concern and obviously we will address ourselves to it and the extent to which it is justified and how we react. We are not persuaded at the moment that there has been a significant change. It is inevitably a grey area because a great deal of medical research of necessity involves researchers in clinical work and plainly the funds of the charities are designed to contribute to the research effort but that inevitably involves them having the patients and a measure of the NHS facilities. Their first duty must be to the patients and they must ensure their research work is carried out alongside the care of the patients. It would be wrong if they found themselves left with a service load not funded by part of the research. I do not think we are satisfied yet that is happening on any significant scale.

Lord Dainton] It has developed over the last few years rather as the financial pressures on the National Health Service have increased. The general relationship between the medical charities and the NHS are first-class and the degree of collaboration and co-operation is splendid, but we are beginning to find this pressure is there and we would be grateful if it could be looked at.

Chairman

23. One important aspect of what we are talking about is SIFT, the special increment for teaching, which, as you know, the Select Committee would like to be called SIFTR in future, putting the word "research" at the end. If you agree with that—and I have not heard any indication that you do not—one is bound to observe that SIFT having been generalised to cover research, 2 per cent. has been

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added to it, which really does seem a pretty miserable way of taking into account the need to cover research in some way through that mechanism.

(Mr Clarke) It is true that the total amount of SIFT has gone up by 2 per cent. It is not 2 per cent. on research. But as we arrived at that as a result of the France Group perhaps I will ask Sir Christopher to explain where we sit and where we continue to go on sitting because I do know where we are but I have been accepting so far the advice of the France Group.

(Sir Christopher France) Can I try and help the Committee over the matter of the figures because again I feel they are rather complicated. We start from an attempt to measure the difference in service costs between a sample of teaching hospitals and a sample of district general hospitals. When that attempt was first made in 1976 a certain differential was established and it was decided to pay 75 per cent. of that to cover the excess service costs of teaching. When the figures were looked at again later —not by my group but by the working party that was reviewing RAWP—the same assessment of the difference was made and two things were discovered. The first was that the difference had narrowed so that the major factor in the equation was reduced. The second was that as SIFT had been enhanced to meet inflation over the years it had increased to a point where it was covering 98 per cent. of the reduced difference. Without going too much into detail, that was increased to 100 per cent. That is the 2 per cent. So one is applying a larger percentage to a smaller difference. It is not, as it were, an analysis which says the service cost of research is 2 per cent. of the difference. It is rather an analysis which says, "The difference has narrowed. It would be wrong to reduce SIFT. Let us now accept that SIFT must cover more than mere teaching. It must cover research, so let us cover the whole of the difference." It could be argued that that approach to measuring the service cost of teaching and research is an inadequate one and I would certainly not wish to defend it on, as it were, high technical grounds. I would only want to defend it in terms of practicality. We have not, in fact, found a better way of doing it. We are going to go on looking at this and we are committed to carrying out a review of SIFT to reach conclusions in 1992. Why 1992? Because following the NHS reforms we will have better information systems in place and it may well be we shall be adopting a more objective approach to the measuring of service costs.

Lord Walton of Detchant

24. Could I say that last night I proposed an amendment asking that SIFT be renamed SIFTR and I understand from what has been said that this is in the Government's mind, but in fact I withdrew that amendment on a technicality but hoped it was a matter that could be addressed again in the report stage.

(Mr Clarke) We are inevitably going into research. We are now out to consultation on how we should restructure the research costs at non-teaching hospitals, but we are not averse to that. Once you get used to a new acronym .... I do not know whether Sir Christopher will develop further how far he sees his group going.

(Sir Christopher France) My group is approaching the end of its natural life but there are proposals for a "Son of France" and we will see whether the powers-that-be approve of that. If they do then that body will certainly be closely involved in the review of SIFT that I have mentioned. Personally I see no difficulty in moving to a SIFTR because that is in fact what we are paying for under the service costs of teaching and research.

Chairman] We are all very conscious in this room that the Health Service does not just consist of doctors and I think perhaps Lady McFarlane would like to come in.

Baroness McFarlane of Llandaff

25. I wondered if I might take up the subject of SIFT and SIFTR more broadly because I am conscious that a number of other professions besides medicine are now being educated within higher education. In terms of teaching and research there are university courses for nurses, physiotherapists and other related professions and it would seem iniquitous that SIFT is allowed for one group of people and not another and I wondered if in the deliberations of the Committee some regard could be given to those costs?

(Mr Clarke) There has certainly been an encouraging increase in the number of graduate nurses and I am glad to say there has been a rather marked increase in the amount of research being carried out in the nursing field. We have not actually yet taken them into the SIFT system, I must admit. It has probably reached the scale where it should and I am prepared to take away the idea and to consider it.

(Sir Christopher France) I think there is a fundamental distinction here because the cost of training nurses is a cost that falls on the NHS in the first place. That is where the major costs arise.

26. I think, if I may interrupt, that with a university-based course that is not wholly true.

(Mr Clarke) They are much smaller. We do have some extremely similar problems when it comes to this whole question of ensuring the training or teaching operations do not put people at a disadvantage in the distribution of funds for the service. Again we are addressing this. But I think although the number of graduate nurses is going up rather rapidly the amount of research is going up equally rapidly.

(Sir Christopher France) I think a point that might be emphasised is that we do not in our analysis of SIFT try to distinguish how the excess costs arise. We are covering all the excess costs, so to the extent

[Baroness McFarlane of Llandaff *Contd*]

that there was a stream of graduate nurses being trained in teaching hospitals, which is where the phenomenon would arise, and that gives rise to excessive service costs, they would automatically be taken into account. In other words, there is no attempt to fillet out the service costs generated by training other than medical undergraduates. There is a separate approach to dental undergraduates but I will not take the Committee into that.

Lord Dainton

27. Just one point if I may, Secretary of State: it always seems to me that in a vast enterprise like the Health Service, or indeed in a large firm like ICI, research is taken more seriously the closer it is in some way to the operational level—then they seem to be more interested in it. Is there any intention in the new post of Director of Research and Development to get them to encourage, shall we say, districts to do research of their own with help and guidance from him, where necessary? I feel where it is self-generated it is often more acceptable and therefore more effective in the end.

(Mr Clarke) I think, with respect, I agree. We would need to have more locally generated research, more research at the operational level. We are going to make it quite clear under the new arrangements that we expect districts to take an interest and we expect most, if not all, hospitals—teaching, non-teaching, National Health Service trust, directly managed—to pay some attention to the research activities they would expect to find within their area. One of the things I think the Director will enable us to do is, firstly, to acquire information about what goes on now and put precisely that steer into the National Health Service, where the Management Executive is going to operate it to devolve far more day-to-day responsibility for the management service down to the unit level, then hold them to account for what they are doing. I imagine the Director as a member of the Executive is going to want to make his input into what we call the accountability and review process whereby the performance of regions is reviewed by the Executive and the regions are then charged with reviewing districts and so on. There is going to be a research line put into that to enable us first to know more about what is going on and to enable him to have an input into how it is all to be encouraged.

28. It is important then, I think you would agree, that they pay for it?

(Mr Clarke) Yes. You surely do not want too much on the districts. I think what we are envisaging happening as a result of putting him on the Executive is that he will make sure the pressures coming from other parts of the Executive do not squeeze out this research activity because all the time the Health Service is under competing pressures it is only too easy for that to happen.

Lord Nelson of Stafford

29. This was one of the recommendations of the Select Committee. We are very glad you have taken it.

(Mr Clarke) It was one of the ones you laid most stress on, I think, Lord Nelson, the first time we had an exchange on the subject.

Lord Rea] Minister, I must apologise for arriving a little late. I was warned about the Trooping of the Colour but I forgot. I have down some points which I hope were not discussed in the ten minutes before I arrived. They are three Cs and three Fs and they relate to the Director. We go back to the discussion we were having about the Director. The three Cs are clout, calibre and credibility, and the three Fs are freedom, finance and funding. I think actually all six are related. The quality of the candidate you are going to appoint very much depends on whether that person, he or she, feels that they are going to be able to choose which type of research they feel is right or what their academic and National Health Service colleagues feel is right, and that needs to be looked at. This in turn depends on the adequacy of the financial resources which the Director of Research and Development is going to be able to deploy. I am not talking about his own salary. I think the calibre of person we are looking for would not be too interested in whether the salary is high. If he is an academic, the salary proposed is very welcome anyhow.

Chairman

30. Secretary of State, you may feel some of the three Cs and three Fs have been dealt with already. You could take the last point perhaps.

(Mr Clarke) I think Lord Rea has been unlucky in that we covered those points in the first ten minutes. I have a perfect view of Anzac Day from my office so I realised the quickest way to get here was by walking along the Embankment. Otherwise, I would have had the same problem. We covered them both but briefly, Lord Rea, I accept the key thing—and, as far as I can gather, the key concern of this Committee understandably—is the clout and credibility of the appointment. We have to address that. We did cover the amount of finance generally available. On salary we went over the question of his grade 2 appointment and considered the desirability or otherwise, the pros and cons, of using secondment as enhancing that, depending where we recruited the man or woman from. The underlying point is that the first thing he is going to do is to want to assess exactly what sort of research he should be commissioning. The next thing is what kind of resources he requires. I accept he is going to have to carry with him people outside in the medical and academic worlds in his decisions upon them. That I think is why we are in fact creating this appointment, to bring somebody in who will establish that.

Chairman] Secretary of State, you have been very generous with your time. I think at this point I

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should ask if anyone who has not spoken yet has a question to put to you. I know Lord Walton has a final question.

Lord Walton of Detchant

31. I have two points. Again late last night (it is relevant to the concerns of this Committee) we discussed the question about the squeezing of funds available to post-graduate vocational and continuing education for medical and all grades of staff in the Health Service. Baroness Hooper said it was the intention of the Department that there should be designated funds specifically protected for that purpose in the budgets. The second point really concerns the climate in the United Kingdom at the moment favouring trials of treatment, and many of these, of course, are funded by drug companies which favour a tradition of openness so that one can work trials and plan trials over large cross-sections of the NHS. Are we going to feel that the United Kingdom will still be a good place to do extensive multi-centre trials if hospitals which become self-governing trusts do not have an obligation to disclose as much as those hospitals which remain in the NHS? I think this is a matter of some concern.

(Mr Clarke) On the first point, Baroness Hooper obviously responded yesterday that proper provision was proposed, and education is essential. I am aware of that. The Chief Medical Officer, were he here, would actually be extremely keen on the continued development of continuous education in the profession and, if the new Director of Research shares that enthusiasm, he will find him as an ally. We keep addressing the question of how we can encourage and support a process of continuous education in the Service. On the second point, firstly I accept it is extremely important that the UK should keep its reputation as a base for research. Everybody argues about why we attract so much inward investment in the pharmaceutical industry. I happen to think it is because they are attracted basically by the quality of work done here, the reputation of the National Health Service, the reputation of our clinical research establishments which have been maintained. I am not quite sure what the fears are about the NHS trusts. Firstly, it will be possible when setting them up to oblige them to take part in research. I happen to believe that will be unnecessary because I do not know of a major hospital that does not think that engaging in research adds to its prestige and attractiveness. I think, nevertheless, we could oblige them to do so, they will not be more closed in their information going to other areas like financial information. We use this jargon of an internal market too readily about these reforms. They will not be able to trade, as it were, with their cards held against their chests. We are envisaging a situation with all cards on the table, costings entirely open and the extent to which they are covering or not covering their costing would be entirely open. In so far as they take part in clinical trials they will not be able to hold back results for some trading advantage compared with other parts of the Service. Nor do I think any pharmaceutical company would take much notice of them if they tried to do that.

Chairman

32. Thank you very much. Might I slip in two quick questions? We have not covered points that were raised in our letter to you, firstly, about freedom to publish where in the White Paper response you said that no consent to publish had been withheld since the research contract conditions were revised in 1987. It is our impression that that statement is not strictly true, and there have been some cases where consent was withheld. I wondered whether you had any comment on that.

(Mr Clarke) I am glad you raised that, Lord Flowers. I am baffled by that comment in your letter and my response is to ask to be reminded of any occasion when we have withheld permission or consent.

It may be that what is being recollected is a controversy which I am told burst out about three years ago when revised terms were produced for the proposed publication of research. We have now reserved to the Secretary of State the power to withhold consent. We do not think it has ever been used. I have certainly never used it and I do not think anybody in my Department has any recollection of refusing permission to publish research.

33. Rather than continue with that now, perhaps it is our responsibility to produce cases, if there are any, and we will let you know.

(Mr Clarke) I do not think it has ever happened.

34. The second question was about computerisation of the National Health Service in the sense of introducing computers to help with the introduction of new policies and, for that matter, computer training of GPs and others who work and are connected with the Health Service. Have you any plans for that?

(Mr Clarke) I think we are going to see the major introduction of computer technology and modern information technology in the NHS. It gets linked again with my reforms all the time but I personally believe that the Health Service needed to get up-to-date with the information technology and make proper use of it anyway and we need to press ahead on that at a pretty brisk rate regardless of any reforms. But we have to make sure we only proceed at a rate which is manageable and produces the right results, is user friendly and delivers to the managers what they want. So we are spending an additional amount at the moment in the current stage of the management initiative but we are rolling it out to most major hospitals by 1991-92. We have greatly increased the support we are giving to the computerisation of general practice. We envisage having all GP practices computerised in a few years' time. We sought to increase the proportion,

[Chairman *Contd*]

particularly before we get into fund-holding practices. They will need to be computerised, to have the software and so on. So I cannot give you figures about what we are spending, firstly, on the implementation of the reforms or what we are anticipating giving to the general practitioners. The key thing about the computerisation process is that it must not go faster than is possible. I think there is a tendency for a large number of suppliers of computers to produce specialist designs for the NHS, which is one of the biggest untapped markets in the country, and they ought to be forming the view that in the Health Service you cannot do anything unless you embark immediately upon investment in new systems and then you begin evolving these "all singing, all dancing" new arrangements and you press a button and you start your new systems. We are rolling it out more cautiously. The new Director is going to require a lot of expert advice in this area if he does not have it. What we have been doing is making greater use of consultancy, I hope good use, because the people who know more about it say there are consultants and consultants and you have to make sure you are doing things properly. That may be too generous.

Lord Nelson of Stafford

35. Do you think that is one of the areas where the operational research people should play a more important part?

(Mr Clarke) That is the biggest single change taking place across the board in the Health Service. I am sure they will.

36. That is where you would concentrate the expertise?

(Mr Clarke) Surely. Probably what will happen is that as you get less dependent on consultants there will be more developments of operational research for the Management Executive because having some direct role to play in controlling this development in the information technology field is going to be absolutely key, it seems to me.

Chairman

37. Secretary of State, I think we can only applaud the fact that you are doing something about it and being cautious about it at the same time. I think I must draw this to a close. Secretary of State, you have been very generous indeed, and Mr Jackson. You have given us a fascinating and constructive morning and it is clear that your thinking is still developing and we are very grateful you are sharing it with us at this stage and allowing us to play some little part, we hope, in its development. If there is anything further we can do together we for our part are only too anxious to try to help. Thank you.

(Mr Clarke) Could I thank you not only for your courtesy but your knowledge and we certainly will ensure we keep you in touch and we will certainly try to take your advice.

Printed in the United Kingdom by HMSO at Hansard Press
Dd 0502960 PS 8350944 C9 5/90

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